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THE KING'S ENGLISH

In some parts of the country the redshank is called the "Warden of the Marshes" because he warns the flocks of waders and shore-birds with whom he feeds, of an enemy's approach. I can hear him now as I write among the sunny creeks of Cornwall, and he reminds me of the task at hand.

Many years ago the pharmacist to the hospital spoke out alone against the dangers which beset medicine. "Roman numerals," he wrote in the Hospital Pharmacopœia, "should not be employed." The campaign against the Latin bogey had begun. To-day we are publishing an article by Dr. Geoffrey Evans on the writing and speaking of English. He points out that loose thinking is born of bastard English and that the surest road to clear writing is early mastery of grammar. He mentions "Fowler's Dictionary of Modern English Usage" as a guide to the student. Of equal value is "Fowler's King's English" from which are taken these five rules of writing: "Prefer the familiar word to the far-fetched. Prefer the concrete word to the abstract. Prefer the single word to the circumlocution. Prefer the short word to the long. Prefer the Saxon word to the Romance."

This last reminds us of Mr. Searle's advice about Roman numerals. Dr. Evans recommends the Saxon word, and warns us of the danger of too literal a translation. Mr. Tubbs, however, teaches his dressers to call a "râle" a "bubble" and other sounds in the chest "whistles and squeaks."

Regular readers of the JOURNAL will have learnt from our correspondence columns in which Dr. Maxwell and others have written at length on the metric system that all is not well in the Apothecaries' shop. The apprentices grumble. In the JOURNAL for November Dr. Bourne wrote about medical catchwords, and warned us how often these were cloaks of ignorance and wrong diagnosis. We can, therefore, feel that this hospital is awake to the dangers of obscuring our thought with foreign words. Are we aware that illiteracy in our own tongue is a common source of confused thinking?

While we are busy putting our house in order we must remember the enemy at our gates. On October 27th a letter appeared in *The Times* from the Warden of Radley, in which he said that "other things are expected of a doctor than technical knowledge . . . doctors should be chosen from men of more than average intelligence. The selection therefore should be made by an examination which tests intelligence and versatility." Mr. Vaughan Wilkes' letter was shortly followed by one from Professor Blair asking for the re-introduction of Latin. These men are sunk in the classical tradition. We honour it and we pass on our way. Greek and Latin have played a great part in the education of modern Europe. Their day is done. And we would point out to Mr. Vaughan Wilkes and Professor Blair that the doctor is born, and not made of Latin and Greek. "The boy," writes Sir Charles Wilson, "who hears the life history of the eel or the story of the migration of birds without a quickening of the pulse has no place in medicine. . . . I do not doubt that science can be made to fire the imagination of more boys than ever carried the Iliad through their lives."

The schoolboy who will be doctor needs to be trained in two studies: observation and writing. Professor Ross never tires of teaching his dressers that "reading maketh a full man; conference a ready man; and writing an exact man." We would add that, for the student, writing must accord with the rules of grammar. Observation is best taught by Pavlov's rule: Observe *and observe*. We believe that this stern discipline of science can produce a doctor every whit as well educated as his unfortunate contemporary who walks with Milton "the studious Cloysters pale."

THE IMPROVEMENT OF MEDICAL EDUCATION

By GEOFFREY EVANS.

The reform of medical education is up for discussion again. Articles on the subject have been written lately by Professor Ryle and Mr. McDonald in the *British Medical Journal,* and *The Times* has had a leading article on the subject. Now I have a circular from The National Union of Students from which it would seem that the subject requires discussion by the students of the several Teaching Schools.

Professor Ryle speaks of the teacher in the wards receiving the product of a previous education in the schools, and he goes on to say that the teacher may justly feel entitled to criticise some of the results of preliminary training. This statement is true, and it goes to the root of the matter. Students come to the wards with so little knowledge of English words and language that they are unable to grasp the precise meaning of what either the patients or their teachers say to them, and they are equally unable to give a concise report of their own observations.

Simple questions rarely get simple answers. In learning medicine the first objective is the observation and record of matters of fact. At the outset the student has to be taught the words to use. About the pulse, for instance, he is taught to count its frequency, to note its rhythm, whether regular or irregular, to describe the rise, summit and fall of the wave, its volume and compressibility, and he is given the words with which to describe his observations. This finished he is asked whether it is regular or irregular, or whether it is hard or soft. It is ten to one that the answer will be given in terms of a *negative to overstatement,* that the pulse is "not very irregular," when in fact it is either regular or occasionally irregular, and "not very hard," when in fact it is soft.

This of course is English as it is commonly spoken by educated people, who often say when they dislike a thing that they "do not like it very much." It may do for a slipshod life, but it is bad in scientific observation and study. As common as the negative to overstatement is the *double negative.* "Nothing abnormal discovered" is a phrase so often used that it is hallmarked by the abbreviation "n.a.d." It is but one of the many "fearful" phrases that medical students learn from their teachers. Another method of avoiding the statement of a simple fact is an answer in *comparative terms.* Inquiry about a man's temperature is likely to be answered by the statement that it is lower than it was, when maybe it is 99 degrees F., normal or subnormal. Or again the answer is often given in terms of presumed *cause and effect.* On inquiry "How did this man sleep last night?" the answer comes, "He was given a sedative last night," when in fact the right reply is "Well."

Some of the language used in the wards is no doubt a "hang-over" from the days when doctors' only interest was disease. Disease was looked for, and if no disease was found the patient had "nothing wrong." And so a man with a fresh complexion is described as not pale, a thin man is wasted, and a stout man obese. The extremes are looked for, and when present are recognised with pleasure, but when they are absent there are no words to describe states of moderate degree, and so men who are lanky or spare have to be described as not fat and not wasted.

Nor is it realised that different people use the same word in different senses. One patient says he is better when there is an improvement in his health, but when another says he is better he means that he is well. If only a student of medicine had made a study of words, time after time he would hear in the first words with which the patient describes his sensations the diagnosis of the disease, in terms of location if not in terms of pathology or aetiology, though the latter might come in the second paragraph of his statement.

It should be the aim of teachers and students alike to use the shortest and simplest words, and when possible to use common words. Diet is a word that is often used when food would be better. Patients are said to consume food and imbibe fluids, whereas the ordinary man just eats and drinks. The use of such words is pretentious. An effort should also be made to reduce statements to their simplest form by avoiding, when possible, such phrases as "tends to" and "is suggestive of," because their use blurs meaning and is a cloak of indecision and loose thinking.

It would be a good thing if we could dispense with some of the foreign words which litter medicine. Only a proportion of students knows that the English of râle is rattle, and few know the meaning of dyschezia and how to spell it. However, we must realise that English words may mean too much and may even be shocking. To speak simply of a rattle

in an ill man might suggest the death rattle of a dying man.

These are illustrations of the fact that neither teachers nor students really know the language they speak because it is not taught in our schools and universities. This ignorance is a veil between students and teachers, as it is a veil between them and their patients. Both the teaching and learning of medicine would be much improved by a better knowledge of this means of communication—that is by the right use of words. There is no one to teach us and so we must learn for ourselves. Those who wish to fill in this gap in elementary knowledge will do well to study an English dictionary, "A Dictionary of Modern English Usage" by H. W. Fowler, and Dr. Roget's "Thesaurus of English Words and Phrases." "The Oxford Companion to English Literature" by Sir Paul Harvey is a great gateway to English writings. Karl Pearson's "Grammar of Science" will give the reader an appreciation of science and scientific method. All doctors as well as scientists should read it. Perhaps to this list should be added "Elementary Lessons in Logic" by W. Stanley Jevons, and Bacon's "Essays," but this is straying beyond my province.

The main thing is that students and teachers of medicine should master the English tongue, and by doing this a great contribution would be made to the "reform of medical education."

REMINISCENCES

Being adecdotes and trite sayings of Past Members of the Medical Staff of St. Bartholomew's. Recorded during Hitler's War by a SEPTUAGENARIAN.

(*Continued*)

SIR DYCE DUCKWORTH, BT.

1. It will be remembered that Sir Dyce began his medical career as a naval surgeon, and ended it as a physician baronet. His naval service appeared to have caused him but little activity, and a very small chance of practical experience. What a change teaching in the Wards must have been! Although a learned physician, he was rather scathing concerning the value of the old round pills. Iron pills—possibly the precursor of "Pink Pills for Pale People"—came forcibly under his, or our, judgment. He would place, say, four varieties of pills in a row, about two feet apart, on the soft deal boards of the Ward, and then ask each of four clerks—hefty or otherwise—to stand with the right foot and all his weight on one pill. If the pill dented the floor and showed no signs of disintegration, Sir Dyce said it proved it could be of no use in the human economy, but if the globe was smashed to pieces, he stated that it might, but only might, be useful!

2. An aphorism of Sir Dyce's has always remained in my memory—"Up the stairs for the heart, down the stairs for the liver." This dictum only concerned the keeping of healthy hearts sound. It may only have come of his rather early dislike of lifts which, as he grew older became gradually less and less.

SIR NORMAN MOORE, BT.

1. Sir Norman was an Examiner for the Nurses' Examinations at St. Bartholomew's, and two stories in relation to this may be cited. In a viva voce, Moore had rather a terrifying manner, it is said.

One question he not infrequently asked to determine the power of observation was: "Nurse, how many Church spires can be seen from the West window of Mary Ward?" This would be the Ward in which the nurse had worked. It would not be unlikely that no Church spires could be seen, so woe betide a nurse who romanced and said "Three, Sir!"

2. But to another nurse he propounded the question: "Nurse, what would you do if a child in the Ward swallowed a tin soldier?" Without any hesitation, nurse replied: "Send for the *house-surgeon*, Sir." Rather hard on the house-physician of the Ward!

It is doubtful whether, in those days, the truly "medical" combat with the hidden soldier was known. But now such a child would be tempted by delicious jam sandwiches with lightly teased out cotton-wool among the tasty fruit, with which the parachutist could safely pass all the dangerous narrows and turnings of the jejunum, ileum and colon, and arrive into the world again well clad with wool.

MR. HARRISON CRIPPS.

1. The writer was very closely associated with Mr. Harrison Cripps—a man difficult to know well. He was a stickler for punctuality, driving into the Square in his nice turn-out always exactly at 1.25 p.m. Punctual and somewhat previous, but tending for an absolutely punctual appearance in the Ward at 1.30 p.m.

Here is a true story. One Friday, Cripps found me waiting for him at 1.25. His

first words, rather startling, were: "I want you to do a post mortem for me. I will let you know later on to-day when and where." I was rather taken aback, as I had never carried out a post mortem on a private case. I merely answered "Certainly, Sir, I will be ready." There were no telephones in those times. All Friday went by and no message came. I had arranged to get away for the Sunday. All Saturday passed, so Sunday had to be spent in London, much to my chagrin. Monday came, and with it Cripps punctual as usual at 1.25. I summoned up courage, and asked as soon as he had descended from his equipage, "What about the post mortem, Sir?" "Oh! I am so very sorry I did not let you know, but the patient is very much better!" No further words on the subject were spoken.

2. Harrison Cripps was a good teacher, impressing upon his hearers facts couched in emphatic phrases. His questions asked in the O.P. rooms always tended to rivet knowledge in one's memory. Once while discussing treatment for hæmorrhage from a branch of the femoral artery, he impressed the dictum that digital pressure on the actual bleeding spot was far better than a pad and bandage. This I have never forgotten, and yet many of to-day's first aid textbooks still ignore the simple direct method of digital pressure and extol the pad and bandage. Cripps illustrated the futility of the pad and bandage method thus:—There is the blood spurting out. The only pad is the lady's 3-inch square cambric handkerchief, the only bandage is her partner's male ditto. Both applied, all looks well. But, ah but, soon a nasty reddish stain appears through a small area of the bandage. In great haste, a serviette is folded into a pad, placed over the whole area and secured by part of a table cloth torn into a bandage. No success. Again the tell-tale stain appears. Then the tea cloth from the drawer near by is tried. Still no good; and in the end a whole sheet is used. Still without success, for the patient died!

3. Having duly impressed our youthful minds with the futility of a pad and bandage in cases of primary arterial bleeding, he would discourse on secondary hæmorrhage from an artery tied in its continuity and from a artery on the face of a stump.

He was enthusiastic, in the former case, about the plan of bandaging from the foot up to the bleeding spot, where a pad was securely applied with pressure from a really tight bandage, and then further light bandaging up to the groin, the whole limb afterwards being elevated.

One dresser—rather a dreamer, but a fine violinist—had not been paying particular attention to the oration. Cripps noticed this, and to bring him back to the realities of surgery, Cripps asked him "Now, Mr. X, what would *you* do for secondary hæmorrhage from an artery on the face of a thigh stump?" Quietly, but quite decisively the dresser replied, "Sir, I should bandage the limb from the toes upwards, place firm pressure on the bleeding spot, and end the bandage in the groin." "Good, good," came from our teacher," but what if the limb had been buried, Mr. X?"

4. Cripps for some reason which would not now hold, was in charge of the Skin Department! Curious for a surgeon!! He was fond of the skin parasites, and particularly of pediculi, which he would persist in calling singular *louse,* plural *lice,* never using the pretty words *pediculus, pediculi.*

One day he caught a louse on the point of a sharp needle, and hoisting his victim upon the petard almost shouted "Is there any one present who has not seen a louse?" To the surprise of all, one aspirant rather tremulously replied "I have not, Sir." "Then here's one, Mr. Y, take it behind the screen and find out whether it is a male or a female." History does not relate whether the correct sex was perceivable by the naked eye.

WILLIAM J. WALSHAM.

1. Many of the readers of this issue of the JOURNAL will remember "Wee Willie" with affection. He was small, but perfectly proportioned. An ordinary operation table was too high for him to reach the ventral aspect of the abdomen of a recumbent patient without a platform.

His right hand was so small and delicate that with the digits held to form a cone, it could be passed whole through the patient's anus into the rectum, and, fable has it, with wrist and forearm bare the middle digit could reach the sigmoid flexure. What need, therefore, for a sigmoidoscope?

2. Walsham did what there was of orthopædic surgery at St. Bartholomew's. In those days there were many cases of genu valgum and genu varum as the outcome of rickets. Fracture of the femur was frequently produced by the use of the long osteoclast, and to see "Wee Willie" at the handles, and to hear the snap of the bone was a sight and a sound which would be worth a "talkie" cinema film to-day.

3. Walsham was taking O.P.'s, and was not in a very happy mood. A big, burly, somewhat boozy brewer's drayman, had a very indolent ulcer, which our teacher thought might be aggravated by an excessive use of alcohol, so he asked the man "What do you

take to drink?" Politely, the drayman replied "I leave that to you, Sir!"

CHARLES BARRETT LOCKWOOD.

1. Sharp, sarcastic but sensible, he was supremely the teacher who made you observe, though occasionally he was inobservant himself.

He certainly did his bit to introduce aseptic surgery. After seeing him prepare so carefully by washing hands, etc., etc., before an operation, it made one shudder to observe him then—inadvertently—pick up the patient's note-board just before starting to operate, and, believe me, he was quite unaware that he had done so, and therefore insensible of all his spoilt toilet preparations.

2. One of my fellow-students, whose eyes may light on this paragraph, was clever at doggerel.

Lockwood could not stand the student, whom he termed the "average" man, forgetting that the world is made up largely of such specimens of humanity.

Our poet therefore immortalised "C.B.'s" opinion thus:—

"Who tries to learn his work by Gray,
O helpless, hopeless lump of clay,
The Average Man."

CASES FROM THE WARDS

By SIR GIRLING BALL, F.R.C.S.

This very interesting case is recorded to illustrate the harmful results, both in diagnosis, prognosis, and lines of treatment, which may follow inadequate investigation as soon after the onset of initial symptoms as possible—and the serious complications which may arise if treatment is postponed when the diagnosis is clear.

The patient, a man aged 57, was first seen by me on September 13th, 1934. He told me that in January, 1929, he had an attack of acute cystitis, pyelitis and a prostatic abscess, which was said to have burst into the bladder. The illness lasted for six week to two months and as a sequel left a persistent pyuria associated with recurrent attacks of fever and right-sided renal pain. At no time was the left loin affected.

Later in the same year he had an attack of abdominal pain, for the relief of which the appendix was removed; it was normal in appearance.

Later in the same year another attack of pyelitis developed, accompanied by rigors, with a large, tender kidney, causing an illness which lasted three weeks, and then gradually cleared up. During 1930 and 1931 there were several similar attacks of fever and renal pain lasting a day or two at a time.

In 1932 he had an attack of left-sided acute orchitis, which cleared up but recurred frequently over a number of years, eventually leaving a hard nodule in the lower end of the left epididymis.

1933 was a fairly quiet year, but there were minor attacks of fever and increased frequency of micturition.

In August, 1934, during the passage of water in the early morning, blood appeared in the urine, unassociated with pain either in the loin or on micturition. This occurred after driving a long distance during the previous day.

A month later another attack of painless hæmaturia developed, lasting for 24 hours, with mildly increased frequency of micturition. This was followed by irritation of the bladder, which was found to be distended with 10 ounces of urine.

X-ray pictures had been taken; the only report made was that the right kidney was small in size, and that there was no opaque shadow anywhere along the urinary tract. No pyelographic or cystoscopic examination had been recommended.

This was the story as told to me.

At the time of my first examination the frequency of micturition was 2-3/1; there was difficulty of micturition in the early morning; the urine was turbid.

There was mild obstruction to the passage of the cystoscope; the bladder contained 6 ounces of residual urine, which was faintly turbid and proved to be infected with B. coli communis and contained a very small amount of pus. The left side of the prostate was obviously projecting into the bladder and was sufficiently large to make a view of the left ureteric orifice difficult. The bladder wall was considerably trabeculated and both ureteric orifices were a little open. These findings suggested that an adenomatous enlargement of the prostate felt per rectum was causing symptoms which required to be dealt with.

Ureteric catheterisation gave quite clear, uninfected urine from the left kidney and turbid urine infected with B. coli communis from the right, which flowed twice as fast and in large quantities, suggesting a hydronephrotic condi-

tion of the right kidney.

There was no evidence suggesting that the prostate had at any time been the seat of an abscess. The prostatic urethra was obviously very sensitive as there was considerable bleeding on withdrawing the cystoscope. This seemed to fit in with the recent hæmaturia following a long motor drive.

These investigations were followed up by a straight radiographic examination, which confirmed the previous record that the right kidney was small in size and that the urinary tract was free from calculi. An intravenous pyelogram showed a small and shrivelled right kidney with largely distended renal pelvis and calyces, and a normal left renal pelvis. The left kidney was large, probably the result of compensatory hypertrophy following destruction of the right kidney.

The reading of the case seemed to be quite clear. The long history of recurrent attacks of renal infection, accompanied in the first instance by a very severe attack of cystitis and in subsequent attacks by orchitis, and the finding of a unilateral renal infection, suggested that the precursor of the infection was probably a primary lesion of the kidney, such as a hydronephrosis of the pelvic type of long standing, possibly congenital, perhaps associated with an abnormal renal artery. It was clear that the kidney ought to be removed. The prostatic findings, however, formed a complication which called for careful consideration before this was done.

The patient did not seek my advice again until 1937, although from time to time he had recurrent attacks of pyelitis and orchitis. In this year, however, there were increasing difficulty of micturition and the worst attacks of pyelitis, repeated rigors, sickness, painful and frequent micturition.

On February 28th an acute retention of urine supervened and 28 ounces of foul-stinking urine were withdrawn from the bladder; a catheter had to be tied in. The intravesical prostatic projection had increased.

A supra-pubic cystotomy was performed; the bladder wall was very thin. All went well for a week and the infection subsided; then, however, the patient suddenly coughed up blood-stained sputum, had a rise in temperature for two or three days, and the respirations rose to 26 per minute. There was evidence of infarction in the right lung with a little fluid in the pleura. This cleared up quite readily. There was a little pain in the chest after the hæmoptysis, which was thought to indicate that there had been a small pulmonary thrombosis. For the first time I heard that as a child the patient had had tubercle of the lung, which suggested an alternative diagnosis to the nature of the renal lesion.

The patient then went for a holiday, wearing a permanent supra-pubic apparatus; he returned four months later, when the prostate was successfully removed. The lateral lobes were quite small, but there was a very considerable intravesical projection. He stood the operation very well, but another rather more severe attack of pulmonary infarction occurred on the tenth day. During convalescence the old epididymitis lit up again.

All went well after this, although the infection of the urinary tract still continued to give trouble from time to time, though of a much less severe character.

On June 7th, 1939, the patient consulted me again, after having had an attack of right-sided renal pain very like renal colic. X-rays were said to show a calculus, with which diagnosis I was unable to concur. The bladder condition was quite satisfactory.

On December 10th, 1940, the patient again had bad pain in the right loin with rigors and the passage of very turbid urine. There was no tenderness in the loin at first, but the kidney gradually became more and more palpable and painful, and, moreover, the temperature persisted and the urine became clear, indicating a hold-up in the renal pelvis. I then advised him to have the kidney explored without more ado, with a view to its removal, to which advice he submitted.

Under the anæsthetic, the kidney was obviously enlarged. On exploration, it was not surrounded by a dense fibrous capsule as might have been expected, but was adherent at one point to the posterior abdominal wall. On attempting to separate it, thick creamy pus escaped from the perinephric tissues and the renal pelvis; on evacuation the kidney collapsed to a small structure. It was very soft and thin walled and the ureter was fragile. There was an obvious kinking at the uretero-pelvic junction, the renal pelvis being dilated above the point and the ureter almost normal in calibre below it. A large abnormal renal vessel was found entering the lower end of the renal tissue and apparently coming direct from the aorta; this was divided and the kidney removed, the ureter being divided as low down as possible without opening up the retro-peritoneal tissues too widely.

The kidney was obviously of the pelvic type of hydronephrosis; the kidney tissue had been almost completely destroyed and the remainder was in a condition of suppurative nephritis. The diagnosis made many years previously was

obviously correct.

There were no complications and the patient made an uninterrupted recovery, without suppuration of the wound, which was a little surprising. The wound had been well flushed with 1/1,000 acri-flavine at the end of the operation and during the suture of the abdominal wall, which was incised by a muscle-splitting incision and not by division of muscles.

The patient was back at work within three months.

In July, 1941, there was another attack of retention due to a small phosphatic calculus temporarily blocking the urethra which passed naturally, relieving the retention immediately.

The patient is fitter than he has been for years. There have been no further serious symptoms, but the urine is still very mildly infected.

This case is full of interest, but a few points are worthy of notice:—

(1) The harmful effects of failure to carry out a full examination of a case of urinary infection are obvious. The patient had had, over a period of ten years, recurrent illnesses which might have been completely avoided, had full investigations been made in the first instance. This must have led to the finding of the lesion in the kidney which called for treatment. It is difficult to understand why this was not done, but it must be remembered that at the date of the original onset it was not generally recognised that acute cystitis is most commonly secondary to infection of the upper urinary tract and only rarely secondary to a genital lesion.

It is all the more surprising that this was not investigated further, as the patient had symptoms relating to the right kidney, which gave evidence of damage by simple radiography.

(2) Following on the above it is obvious that in a case of infection of the urinary tract, a complete examination of the tract must be made in order to discover the presence of a predisposing lesion liable to be the cause of it.

(3) This is a typical case illustrating the spread of a renal infection to the bladder and to the genital organs, which will lead to recurrent attacks likely to persist until the original focus has been removed.

(4) Perhaps the greatest interest in the case lies in the difficulty in judgment as to treatment, owing to the subsequent enlargement of the prostate causing obstructive symptoms.

Until the prostatic symptoms developed there was no question that the kidney should have been removed. When the lower urinary tract was investigated, it was clear the removal of the prostate was required. At the same time it appeared to be undesirable to do this with a badly infected kidney still present, despite the fact that there appeared to be good function in the opposite kidney. However, the treatment of both conditions was postponed and nature decided for itself how it desired that the body should be treated. The attack of acute retention demanded attention, and later on the rupture of a pyonephrosis called for urgent surgical treatment.

(5) Lastly, the case shows what the body will put up with even when badly treated. Recurrent illnesses, damaged kidney, infection for ten years, obstruction to the urinary tract, pulmonary embolism on two occasions, pyonephrosis and perinephric abscess, calculus formation.

Returning to the original motive for this record, had the complete investigation of the urinary tract been made in the first instance, most of this might have been avoided.

TO IMHOTEP

To Imhotep, good students pray,
That if they qualify one day,
Their patients will not ever die
Of 'noxious things which putrify.'
" Let not the mixtures we have sent
Cause their 'humours to ferment.'
If the fat boy still grows fatter,
May we find the 'harmful matter';
And if Lotty still stays thin,
Let us remember Santonin.
If patients bring up stinking vapours,
Keep the scandal from the papers.
Oh, Imhotep, provide for us
Much 'goodlie beneficial pus.'

If evil spirits haunt the brain,
Help us cast them out again.
Give us herbs and give us balm,
Give us drugs which do no harm,
And if they fail to do much good,
We will simply swear they should.
Bring us those who'll pay large fees:
No D.O.T.'s or B.I.D.'s.
Inflict them all with wens and blains,
Ravish them with aches and pains;
Knock them down and break their bones,
Fill their bladders up with stones.
And if our patients shirk their bills,
Then visit them with divers ills."

CORRESPONDENCE

GOBBO HITS BACK

To the Editor, St. Bartholomew's Hospital Journal

Dear Sir,

My attention has been called to an acrimonious outburst in your otherwise prosaic periodical—

Hullo, hullo, what's all this about?

Go away.

Ghastly pallor, beads of perspiration, dilated pupils and a fine tremor of the lips and fingers. Gentlemen, you observe here a most arresting clinical picture.

D'you mind haranguing your clerks in Hades? I'm trying to write to the JOURNAL.

Hardly a sufficient cause for the syndrome. What are you writing about?

Didn't you see the letter from *In Arduis Fidelis* in the last number? Here look at it now, you illiterate recluse.

Phew! A purulent effusion, if I might coin a phrase. A downright empyema.

Your humour makes me sick.

Don't read too much of your own, then, or you'll die. What roused this typhoon of bitterness and recrimination?

This passage in the October Friern News. Read it.

Very tactless, old boy. I suppose you were trying to be funny.

Guilty, my lord.

A deadly error. Have you read Lord Gort's Despatches?

Yes.

And are you sorry for what you said?

Yes, sir.

Then take a hundred lines and be more careful in future. You could publish quite an entertaining little volume entitled "Indiscretions of a Friern Correspondent." I think you'd better give up writing the Friern News.

I have. If you look at page 57 you'll see another boob's been inveigled into doing it. If he sticks it for three months, I'll . . . I'll give him a season ticket on the Brains Trust. First and last the BART.'S JOURNAL has caused me more trouble and annoyance than any other single cause in a not uneventful life.

Do they know you hold the King's Commission? You ought to come up in uniform one day and drill them.

Now *you're* trying to be funny. For goodness' sake go away so that I can write this letter.

Well, make it short and straightforward. Doctors are horribly verbose as a tribe. D'you know what I read the other day for barium meal? "Radiographic examination associated with barium ingestion." Ugh! The man who wrote that needs a dose of Mist. Dynamitum.

You'll get one yourself if you don't clear off. I'm going to write this letter afresh. Here goes:—

Dear Sir,

I am extremely sorry to have been the cause of the pungent comments of *In Arduis Fidelis* in your last number. I can only plead that the ungenerous passage in my article was written in a moment of great haste and thoughtlessness. Nothing was further from my mind than to give offence to a body of soldiers who have always been good friends with the students at Friern, and who are, as everyone knows, doing their bit just as thoroughly as anyone can.

Nothing will persuade me ever to darken your columns again.

I remain, Sir, with many apologies,
Yours faithfully,
GOBBO.

Friern, Guy Fawkes Day.

PRIVAPARA

To the Editor, St. Bartholomew's Hospital Journal

Sir,

The Law may be an "Hass" but I fear the case you mention does not establish the proposition. It is correct that there is no presumption of law regarding the age at which a woman is past the age of child bearing, and in view of the remarkable and authoritative case you mention I doubt whether as a broad principle it could be put otherwise: is "Gamma," who is no doubt a medical man, prepared to stake his professional reputation on the maximum age at which a woman can bear a child or the minimum age at which she cannot? The Law, however, does provide a remedy for the difficulty in that it allows trustees and others to apply to the Court for permission to presume that from the circumstances of a particular case a woman is in fact past the age of child bearing. I will only trouble you with one case: Davidson v. Kimpton, Law Reports, Chancery Division, vol. 18, p. 213, where the Court allowed a fund to be distributed on the presumption that a woman of the age of 54 would not have children.

DELTA.

October 22nd, 1941.

All contributions for the January number should be sent in before December 15th.

You are asked to write legibly.—Editor.

THE PIED PIPER OF SMITHFIELD

OBITUARY

H. E. G. Boyle, O.B.E., F.R.C.S., D.A.

A Memorial Service to Mr. Boyle was held in the Church of St. Bartholomew-the-Less on October 22nd. We print below the Address given by Mr. Reginald Vick at this Service.

We are assembled at this Service to remember
Henry Edmund Gaskin Boyle,
Anæsthetist and Lecturer on Anæsthetics to the Hospital.

In remembering him, our thoughts naturally turn in deep sympathy to Mrs. Boyle, who for so many years shared his joys and his sorrows, his work and his relaxations—and of late, as we all know, his anxieties and his suffering. It may literally be said of him that lately ill-health has dogged his footsteps, and as the months passed his steps faltered more and more until he found himself lying on a bed of suffering in his last long and distressing illness, from which he is now happily released.

In the death of Boyle, Bart.'s mourns the loss of one of those many sons, who some to a greater and some to a lesser degree have added lustre to her Great and Ancient Name.

Anæsthesia, perhaps more than any other branch of medicine, can claim to concern itself particularly with the alleviation of human pain and suffering, and it was in this, his own special branch, that Boyle spent the greater part of his active professional life. He is—rightly—counted a Pioneer along at least two lines. He was one of the first to introduce and practise the administration of Gas and Oxygen Anæsthesia—a type of anæsthetic, which has now found a firm place as a satisfactory routine procedure. He was one of the first to introduce and practise the method of Endotracheal Anæsthesia—a method, since perfected, which has meant "safe" anæsthesia in innumerable difficult cases.

Boyle will long be remembered by the apparatus which bears his name.

During his busy professional life he worked hard in all the branches of his own speciality, in teaching, in lecturing, and, within recent times, in examining for the Diploma in Anæsthetics of the R.C.S.

For his services in the last War, he was appointed an Officer of the Order of the British Empire and he later received the rare distinction of being made an Honorary Fellow of the R.C.S.

He belonged to a very famous generation of Bart.'s men, so many of whom unfortunately have already left us. One of my most vivid memories of him was at the time when Bart.'s suffered an irreparable loss by the death of Etherington Smith. Boyle was one of his greatest friends, and I have always thought that although all this happened years ago Boyle never really forgot the loss of so great a friend in circumstances of such tragedy.

In private life, he was one of those who found comfort and happiness in the warm, congenial and philanthropic atmosphere of Freemasonry, a Brotherhood in which he held high office.

His interest in students was deep and sincere. He was an ex-President of the Abernethian Society and an ex-President of the Students' Union. He was rarely absent from the stand at Richmond in the days of the thrilling cup ties, which now seem so far away.

His sport was cricket, and he often displayed his skill at the Past v. Present Matches at Winchmore Hill when he enjoyed so much all the happy associations round which such a function revolved.

In these few words, I have endeavoured to sum up briefly Boyle's life—his work and his interests.

The generations come and go and all must pass. Of Boyle, we would say—

He lived his life to the full.
He served his Mother Hospital well and truly.
He served his Fellow Men well.

And, as it was his lot to suffer much, we may rest assured that he will enjoy now that Peace which he has so truly earned.

It is not easy to add anything to the sympathetic appreciation of H. E. G. Boyle delivered by Mr. Vick at the Memorial Service held at St. Bartholomews' on October 22nd. Indeed it must be a matter of deep regret to numerous colleagues, pupils and friends, among them myself, that war conditions made it impossible for them to be present on that sad occasion to render a last tribute to his memory.

"Cocky" Boyle, to refer to him by the name by which he has been affectionately known to generations of Bart.'s men, was born in Barbados in 1875, and had his early schooling there. When once he commenced his medical work at St. Bartholomew's he made his home in London and only returned to the Islands for occasional visits. Soon after qualification he became Resident Anæsthetist at the Hospital as a colleague of W. Foster Cross. A few

years later when it was found necessary to increase the number of Visiting Anæsthetists they both received promotion on to the Senior Staff at, or about, the same time. When Cross retired he succeeded to the position of Senior Anæsthetist to the Hospital, a post he held until his progressive ill-health made retirement necessary comparatively recently. He was then elected to the Consulting Staff.

The pioneer work for anæsthesia done by Boyle at a time when the specialty was in urgent need of awakening from its somewhat dormant condition was well indicated by Mr. Vick and need not be elaborated here. His activities in this connection were much stimulated by the visit he paid to Canada and the United States, the first visit paid by any anæsthetist, as such, to those countries, to investigate the advances that were being made there. Across the Atlantic he made lasting friendships with the leading anæsthetists. One might mention among others Gwathmey, McKerson, Wesley Bourne, and, that extraordinary organiser of anæsthetic interests all over the world, the late Dr. McMechan. On his return Boyle induced the Hospital to import the first Gwathmey Gas and Oxygen machine that came to this country, and which, largely owing to improvements and additions devised by him, proved the prototype of the thousands of machines now in general use.

He was a member of the old Society of Anæsthetists and when that became absorbed in the Anæsthetic Section of the Royal Society of Medicine he was a very active member, contributed a number of papers, and presided over its meetings in 1923. From its foundation he was a member of the editorial board of the *British Journal of Anæsthesia.* He was an original member and a strong supporter of the Association of Anæsthetists of Great Britain and Ireland, and when the Diploma of Anæsthesia was instituted he was naturally one of the first to receive it without examination, and one of the first pair of examiners appointed to conduct the examinations.

As a teacher he earned the gratitude of generations of students by the thoroughness of the instruction he imparted and its essentially practical nature. There had long been a tradition that a Bart.'s man could always be relied upon to give a good anæsthetic, and Boyle took good care that this tradition should be preserved. His lectures were clear and instructive, but he regarded them as subsidiary only and stressed the view that the art of anæsthesia could only be learnt in the operating theatre by numerous administrations and careful attention to the condition of the patient. His elementary textbook "Practical Anæsthetics" ran to three editions.

He was a master in the art of reconciling the frequently rival claims of hospital and private practice, and never allowed the latter to interfere with the former. He was a model of punctuality in attending his hospital operation sessions of which he probably undertook as many as any anæsthetist in London.

During the long years in which he was responsible for the anæsthetic service of our Hospital he maintained that service at a very high pitch of excellence. This was done by careful selection of Resident Anæsthetists, and very kindly and helpful co-operation with them. To his fellows on the Visiting Staff he was an ideal colleague, ever ready with advice or actual help should any difficulty arise. He had indeed that happy but rare power of exercising a strong controlling influence without the slightest suggestion of interference. After being perhaps more closely associated with him than anyone else in this work for many years I feel that, however inadequate this appreciation may be, no one could write it with greater sincerity or esteem.

C. J. H.

A CASE OF FOREIGN BODY IN THE OESOPHAGUS

By B. M. Wright, M.B., B.Chir.

The following case might have been subtitled "A Warning to Locums," as it is an excellent example of the importance of taking a careful history, and of the danger of accepting a ready-made diagnosis.

I was doing a locum in a remote country village, the local doctor having retired to bed with jaundice. He had not been well for some time, and he had also had a great deal of family worry, which facts have, I think, a bearing on the events which follow.

Among the cases which he handed over to me was that of Ernest, aged 20, a labourer, who was said to be suffering from laryngitis. The only history I had was that he had had it for a fortnight, and had great difficulty in swallowing.

When I first saw him he was in bed and

looked ill and wasted. I was struck by the fact that although he had great dysphagia, and could not swallow anything more solid than custard, and was very tender in the region of his larynx, his voice appeared normal. However, I was in that state of bewilderment that is inevitable at the beginning of a locum, when you do not know where anyone lives, and cannot remember what is wrong with them anyway, so I took the line of least resistance and continued the same treatment, which consisted of rest in bed, and a diet of slops and aspirin. The doctor had a large sweet jar in his dispensary full of 5 gr. aspirin tablets coloured pink, and I found them a great standby for the innumerable cases of rheumatism, especially those who couldn't take aspirin because it didn't agree with them.

After about a week I began to get my cases into some sort of perspective, and I began to be suspicious of the supposed "laryngitis." I went to see Ernest frequently, and examined him repeatedly and with great care, but failed, I regret to say to take a history.

The only positive findings were:—

1. A missing right upper incisor.
2. Tenderness and œdema in the region of the larynx, but chiefly in its lateral aspect.
3. Considerable bodily wasting.
4. Some suspicious signs in the chest at the left apex.
5. A strong family history of tuberculosis.

On the strength of these findings, and the fact that although he was steadily improving, he was still very ill, and his laryngitis was like nothing I had ever seen or heard of before, I decided to get his chest X-rayed.

This was, unfortunately, far from being the simple and relatively inexpensive procedure that I had been used to in hospital, since it involved a 20-mile journey to Cambridge, and a dispute as to who was to pay for the transport.

However, I managed to arrange everything, and his mother came to see me the evening before to discuss the details.

In the course of conversation, she said casually, "It's a funny thing, doctor, but we can't find Ernie's false teeth, do you think he might have swallowed them?" I leapt into the air and said, "What false teeth? I never knew he had any."

I then elicited the following history.

Two years previously, Ernest had had a motor-bicycle accident, in which he sustained severe concussion, and had one of his front teeth knocked out. He had recovered from the concussion, but such was his sensitiveness about his personal appearance that, in spite of the fact that he still had many more teeth than most of his contemporaries, he had, at great personal expense, had a small plate made carrying a substitute for the missing right upper incisor. This was fixed in position by being glued to the hard palate by a dental fixative.

One month previously, and a fortnight before I first saw him, his supply of fixative had run out. Nevertheless, as he was going to a party, he had worn his denture, and, probably as a result of the party, he had gone to bed with it in situ.

In the middle of the night, he woke up with a severe pain in his throat and a choking sensation, but no dyspnœa or stridor. His mother gave him a drink of water, but he could not swallow it. They did not send for the doctor at once, because they knew he was not well, and when he came in the morning, he could find nothing except great tenderness in the region of the larynx, some redness and œdema of the throat, and complete inability to swallow either solids or liquids.

Probably for the reasons given above the doctor did not perhaps give the case all the attention it deserved, but made a diagnosis of acute laryngitis, and treated him symptomatically. Shortly afterwards he became so ill himself that he had to retire to bed, and I came on the scene.

Meanwhile, Ernest managed to survive, in spite of being unable to take even water, the possibility of introducing fluids by any other route than the mouth being of course quite unheard of in those parts.

About three days later, when he was just beginning to take a little fluid and to recover somewhat, his mother was washing his face when she observed the gap in his incisors and said to him "Where's your tooth, Ernie?" He said, "I dunno Mum, it must have fallen out, perhaps it's in the bed somewhere."

She said, "Are you sure you haven't swallowed it?" "Oh, no!" he said, "I couldn't have swallowed it, my throat's much too sore!"

The mother was apparently satisfied with this explanation, and it was only the continued absence of the denture after three weeks which re-aroused her suspicions. The other striking facts which I have given in the history were only elicited and put in their proper time relationship after careful cross-questioning.

The rest of the story is soon told. X-ray showed the denture in the œsophagus, just below the larynx, and it was removed with great difficulty, having been in position for 31 days. Fortunately no complications ensued, and Ernest made a rapid and complete recovery.

BOOK REVIEWS

BROMPTON HOSPITAL REPORTS, Vol. IX, 1940. (Price 5s. 7d., post free, from the Secretary, Hospital for Consumption, Brompton, London, S.W.3.)

This volume contains articles dealing with war injuries of the chest, pulmonary tuberculosis, carcinoma of the lung, spontaneous hæmothorax, and other subjects. The high standard of interest and of scientific enquiry is maintained.

Mr. J. E. H. Roberts' article on war injuries of the chest provides a valuable and brief resumé of the problems arising in the treatment of these injuries. The article is made especially valuable by the stress placed upon the basic principles involved in each type of case, the issues being cleared from all unnecessary mass of clinical detail.

As a continuation of this subject Mr. C. Price Thomas has dealt in a similarly brief and clear manner with the Late Effects of Penetrating Wounds of the Chest.

In an article upon Primary Carcinoma of the Lung, Mr. Roberts stresses the need for early recognition of the disease in cases where signs are absent, and dry cough and possibly slight hæmoptysis are the only symptoms. Bronchoscopy here is essential. The indications for operation are fully discussed.

Tuberculosis is the subject of several articles. Dr. J. G. Scadding analyses the differential diagnosis of pulmonary tuberculosis, in cases where the sputum is negative, in a full and informative manner.

Dr. R. G. Wingfield discusses the socialogical problems involved in the prevention of pulmonary tuberculosis. He concludes that early diagnosis is the crux of the matter, and that radiology should be part of the routine examination in every suspected case.

In a very full article the relation between chronic iridocyclitis and tuberculosis is investigated by Dr. W. D. Wykeham Brooks and Dr. E. Rohan Williams. They conclude that such relationship definitely exists.

Space prevents reference to the remaining articles, which maintain the high level of interest already referred to. The format and the excellent X-ray illustrations have in no way suffered from war-time production.

INSTRUMENTS, APPLIANCES AND THEATRE TECHNIQUE. By EVELYN PEARCE. With 230 Illustrations. Price 6s. (Faber & Faber.)

This latest book by Miss Pearce should be found extremely useful by many nurses to-day, especially those working in Military and Red Cross Services who may be called upon to assist with work in which they have had little, if any, previous experience.

Theatre Technique employed naturally varies in different hospitals, to comply with the Surgeons' wishes, and to keep abreast with modern bacteriological findings and wartime facilities; this applies especially to methods of sterilisation.

The cost of this book is rather high for one intended purely for reference, but no doubt this is due to the increased cost of materials and the fact that it contains many excellent and useful illustrations.

This is a compact and extremely comprehensive book and should prove invaluable to those suddenly called upon to work in an operating theatre.

TEXTBOOK OF HISTOLOGY. 2nd Edition. By E. E. Hewet. (Heinemann, 17s. 6d.)

This textbook was first published in 1937 and was specially written for medical students. The second edition has not involved any drastic changes though the section on the development of blood corpuscles has been brought up to date, and some interesting information as to arterio-venous connections added. New and quite excellent photomicrographs have been added to the section on bone. The photomicrographs are throughout of a high standard especially some very fine pictures of muscle spindles, synovial membrane and nerves of the human carotid body. The general principle maintained in this book of giving photomicrographs of tissues under fairly low power and "diagrammatic drawings" (as the author calls them) of the minute structure may not appeal to some readers. These diagrammatic drawings are neither diagrams nor straightforward drawings; that is to say, they do not obey the rule that every line should represent some specific structure which should hold for diagrams. Nor do they give a pictorial representation of the tissue in its full complexity. In spite of this criticism they should succeed in giving the student a very fair idea of the essential cell structure of tissues, and combined with the photographs and practical work on his own sections he should be fully equipped with an adequate knowledge of histology so essential to a proper understanding of pathology. In this connection the author is careful to draw attention to physiological, as opposed to pathological, variation in structure. It is doubtless as a result of many years' teaching at a London hospital that the author has refrained from a purely academic treatment of the subject and has obviously always borne in mind the fact that the student's study of histology will soon give place to pathology and its relation to clinical medicine.

The book is beautifully bound and printed on excellent paper, and should prove of great use to both preclinical and clinical students.

FRACTURES AND OTHER BONE AND JOINT INJURIES. By R. WATSON-JONES. 50s. (E. & S. Livingstone.)

This is a book primarily for the fracture surgeon. It opens with some ten chapters which are devoted to the principles of fracture treatment in general and then passes on to a detailed account of the dislocations and fractures in all parts of the body. The book is in every way up to date even to the extent of the treatment of war wounds complicating fractures. It is perhaps rather too large a book for the individual medical student to possess and read from cover to cover, but at whatever point he may choose to explore it he is certain of finding not only new and interesting facts, but facts which are illustrated by some of the best diagrams and illustrations which have ever been assembled between the covers of a medical textbook. The text itself is extremely readable and easily understood which is not always the case in an advanced textbook of this type. The book is indeed a great credit to the Liverpool school, and is one which is obviously destined to be the standard work on Fracture treatment for some considerable time.

ROUND THE SECTOR

At CAMBRIDGE

There is no doubt an old adage that goes, "To copy a comrade calls for contempt." Be that as it may (and it may well be true), there is also a counter-adage, if the terms will be excused, that puts it "Nothing venture, nothing gain." And so, with profound apologies to him from whom the idea is borrowed, here is a representative conversation between two pre-stooging, pre-stoating, pre-clinicals to whom all the world's a textbook and they the readers therein:

"Done the Viva?"

"Aye, if I had a pelvis like that female I should throw it away and use a flour bin."

"If you had a pelvis like that female, you would be in a pretty sorry plight right now."

"A trifle superfluous, that remark. You know what I mean. I've done my embryology."

"I am glad you say 'done,' it is so perfectly ambiguous: 'done'—finished and learned or 'done'—just finished; so near and yet so far. I admit, these vague expressions can be profoundly useful to one when engaged in a potentially embarrassing conversation. Imagine telling the powers that be that learning Neurology is pseudo practicable, meaning that it could be learned were it not for its deeply enshrouding mysteries."

"Or proclaiming that Time is the hot favourite and Physiology a rank outsider. Such an announcement would pass unnoticed until eventually and subconsciously deciphered."

"And then the sparks would be flying and you the flint."

"Anything in the viva this morning?"

"Oh, he pointed once to what appeared to be nothing more than the last meal of the subject, and said, 'What's that?' 'This, sir?' I parried. 'Yes, that,' he said. I said, 'Oh, that—'"

"Third method of hedging, yes carry on."

"Well, I told him."

"And you were wrong, of course. Sounds a fairly routine sort of viva to me, although it does surprise me sometimes how they will differ. One will be startlingly short with a familiar signature as the climax, and the next will be strength-sapping in length with a glorious lemon at the end. The scheme is crackers. A little forgery on our part would solve the whole issue."

"Must you give away trade secrets? You know I'm responsible for at least two signatures of people afraid lest the sheets are given more than a cursory glance."

"Sorry. Still, as a point of ethics I think two things ought to be eliminated from our work-a-day lives. One is forgery and the other is the mass of mustard seeds that grows into a grotesque forest."

"Are you alluding to the cultivation of spices or is this another of your vile metaphors?"

"The seeds I refer to are habits such as: eternal sucking of a pipe which has never smelled tobacco; head nodding during vivas; sucking calf noises in lectures; and writing 'a'rtnoon' above the vivas on the blackboard."

"Oh, yes, and futile laughter aimed at wheedling a much desired signature from an unbribable demonstrator. The psychology is there but the subtlety of application is absent. Far better to say at the end of a viva, 'I have a pen, sir, try it out on my viva book, you may find it a little difficult'."

"Ah, how remote those viva days seem now, I took my last one a week ago. Which reminds me that a terminal viva is impinging on my sense of well being, I think a little work is indicated."

"Alright, I can take a hint, cheerio, and I hope your rabbit dies."

* * *

At HILL END

Apart from the fact that Mr. C. J. Carey has left us for the army, and that Mr. G. C. Mackay, whom we are glad to have with us again at Hill End, has taken his place on the Chest Unit, there is no news from this sector. We have considered imitating our Friern contemporaries in producing a "news" without news value. "Friernites" would probably rise as one man and protest against this breach of etiquette, but we could then point out that imitation is the sincerest form of flattery. They may, however, rest assured that this will not happen, because we have scoured the hospital and cannot find anyone with a sufficiently low I.Q., who is willing to write such a "news."

WEDNESDAY, DECEMBER 18TH. A recital of

Christmas Carols will be given by the Choral Society. The rehearsals have recently been transferred from the buffet to the reception hall to make room for the swelling numbers and increased lung power of the Choristers.

FRIDAY AND SATURDAY, DECEMBER 20TH AND 21ST. The Dramatic Society are putting on a Christmas Show, similar to the past revues. The Committee meet every other evening and from them we gather that rehearsals are due to start any day.

WEDNESDAY, DECEMBER 31ST. New Year's Eve Ball. Dancing to the Melodicals, with spot prizes and novelties.

* * *

At FRIERN

[It is with great regret that we have accepted Gobbo's resignation from office. Being constantly attacked from all sides and at once has proved too much even for his robust constitution—though this has been undermined of late by the Ice Age which has once again returned to Friern.—Enter Anton.—Ed.]

You seem very absorbed in that paper. May I ask what there can be in a BART.'S JOURNAL to merit such deep attention?

As a matter of fact, I'm reading the Friern Section of the "Child's Guide to Bart.'s." It's extremely instructive. For example, there are "Two lecture theatres . . . furnished with cushioned benches and blackboards." Sounds palatial, doesn't it?

True. But much depends on one's powers of interpretation. A cat should be a fair judge of a cushion: yet that sinister animal that leaps out on people in the park gave ours up in disgust after one abortive attempt at slumber.

Some of our fellow students seem to be more fortunate. I think David Pelham could sleep on the floor if he had to. But see here—there's more to come. "Men may read in one of the lecture rooms . . . or in the Abernethian Room." What do you suppose that means?

Probably a *Cri du cœur* from someone who *did* try to read there in the pre-fire days, I should think.

Perhaps so. But let's not be too critical. I understand Gobbo is no longer writing the Friern News. I do hope the new man will be readable.

He probably wonders what on earth constitutes news, poor fellow. Personally, I think he ought to include "The Case of the City Policeman" or "The Vanishing Lump." I shall never even doubt one of R—— V——'s stories again. Here's one come true before my eyes.

You mustn't be disrespectful to your seniors. It's infectious. I suppose you read Guy Richards' letter last month?

I did. And considered it a very creditable effort, though perhaps tinged with pugnacity. Like Oscar Wilde, I wish I had said that.

I'm really rather glad I didn't. When I was a fag at school I always felt a bit uneasy when I'd been cheeky to the Head Beak.

It's worth a hundred lines at least. And speaking of Lines, I see Cambridge's own has been credited with some in the literature.

Ugh! What a pun! Still, it's a relief to be able to fit an actual human being behind the name for once. In spite of Mr. Hamilton Bailey's efforts, I can't do the same for Messrs. Hand, Schuller, Christian and their ilk.

I wish myself they'd give up naming diseases after the giants of the past. It's just one more strain on one's memory. A scientific name based on some aspect of a disease does at least tell you something about it—if you're sufficient of a classical scholar.

There you miss the spirit of the old nomenclature. Its object was not, and is not, to convey knowledge. It is to make of you and me vocal monuments to the Grand Old Men of yore. That and that only.

But surely tradition isn't as strong as all that. Reason must get a look-in sooner or later.

Later, I suspect. I've got a private theory about this perpetuation of men's names in disease form. I fancy all the eminent men have a hope, even the most modest of them, that one day their names will have joined those of William and John Hunter through the medium of a tumour or a test or an operation. So you can't blame them for keeping the system going.

An interesting possibility. However, I've no time to argue the point. Are you coming on the round?

Yes. Let's go.

ANTON.

SPORTS NEWS

RUGGER

October 4th, v. London A.A. XV, at Chislehurst. Won 19—3.

The A.A. team played as a collection of players rather than as a team and this allowed the Hospital three-quarters to take advantage of many openings. The game was interesting to watch as the standard of combination was good and there were several newcomers to the side who had not been seen before.

R. J. Alcock's hooking had improved from the previous season, and until he was injured in the second half, the Bart.'s outsides had more opportunities than had fallen to their lot for some time.

Tries were scored by C. S. M. Stephen, J. W. G. Evans (2), P. R. Hawkes and J. T. Marcroft.

October 11th, v. Training Battalion Welsh Guards, at Chislehurst. Lost 3—19.

This game was against the best team now playing in London. Many of the Guards' side were Rugby League players, four of them internationals, and it is unlikely that the Hospital defence will be so thoroughly tried out again this season. In spite of the Guards' powerful attack they only crossed the Hospital line three times.

Both packs played well, the play throughout being vigorous in the best Welsh style and both sides giving as good as they got. Apart from the indifferent Bart.'s hooking there was nothing to choose between the two packs.

Outside the scrum the Welsh Guards had more original ideas when attacking and, using the inside pass to its best advantage, combined with good backing up, they found one or two openings in our defence. This does not mean to say that Bart.'s were weak in defence. On the contrary, the tackling was good but the introduction of Rugby League tactics into the Union game showed how good teamwork and new ideas could result in the scoring of tries against a sound defence. A lesson which it is hoped was well learnt by the whole Bart.'s team.

October 18th, v. St. Thomas' Hospital, at Guildford. Won by 2 goals, a dropped goal and a try to a dropped goal and 2 penalty goals.

The game was played on a prep. school ground which was about 20 yards too short, and narrow in proportion. This made it very hard to score tries by any means other than by straight running, and although the Bart.'s outsides made a good deal of ground whenever they had the ball they only crossed the Thomas' line three times.

J. C. Gibson played a good game at full back. His kicking against the wind was always beautifully judged with long curving kicks. J. R. Moffat, among the forwards, also was outstanding.

J. W. G. Evans dropped a goal, and tries were scored by L. A. McAfee, N. A. Campbell and Evans.

October 25th, v. Middlesex. Won 9—3.

Our opponents kicked off and it was evident from the start that we were handicapped by the absence of our regular hooker. In this department "Ginger" Steed had matters all his own way and secured the ball eight out of ten times from the set scrums. With this advantage Middlesex were dangerous in the early stages and only determined tackling kept them out.

However, we soon settled down and carried play to our opponents' half with some clever three-quarter movements. Here John Evans led the way with one or two delightful cuts through, but movements came to an end because of inefficient backing up.

After twenty minutes Corbett, a newcomer to the forwards, picked up the ball from a loose scrum and dived over the line by the corner flag to score a good try. The kick from the touchline fell short. Soon after this Middlesex equalised with a similar type of try which was also unconverted.

Bart.'s were now playing better and on the few occasions when we got the ball McAfee, who never put a foot wrong all afternoon, set the three's going splendidly. Shortly before half-time Hawkes landed a good penalty goal and we changed ends 3 points up.

The outstanding feature of the second half was Campbell's spectacular try. The ball went along the line to the winger and the latter finding himself hemmed in punted ahead and followed through. The ball bounced kindly and Campbell took the ball in his stride and raced away to score under the posts. The kick at goal went wide.

After this Middlesex were a beaten side. They reached our line with forward rushes but never really looked like scoring. So the end came with a good win for Bart.'s.

November 1st, v. The Preclinicals, at Chislehurst. Won 22—3.

That the prestige of the Hospital XV was maintained in this game mattered nothing. What was important was to find that among the Bart.'s preclinical students now exiled to Cambridge, there are several young players coming on who will be able to fill the gaps left in the team when some of the old-timers who have been in the side for the last five or six years leave the Hospital during the next twelve months.

The Hospital, still without R. J. Alcock to hook, were otherwise at full strength. Their play, however, was not very inspiring and the scoring was mainly due to a lack of organisation in the Preclinicals' defence. The art of defence is as important at least as the art of offence. Perhaps if a good textbook on Rugger were to be added to their medical library at Cambridge this would be improved!

Of the Preclinical outsides, Pitman made one or two good breaks through the centre, but usually spoilt his good work by failing to pass once he had beaten his man. His defence, too, was very weak but he has plenty of speed and if he can improve these two faults, he will become a more useful member of the team. Hawkes at fly half has good hands but is slow off the mark and rather uncertain about going through an opening. However, his rugger sense is sound and his kicking good. He must concentrate on more speed. The forwards all got through a lot of hard work and Jones was usually to be found near to the ball although this could be said of the whole pack.

Of the 1st XV only R. L. Hall, C. S. M. Stephen and J W. G. Evans played really well.

November 8th, v. King's College Hospital, Away. Drawn 8—8.

The re-appearance of R. J. Alcock as hooker was welcomed by the backs who had seen little of the ball from the set scrums for a month. The game was fast and open with, in the words of an impatient spectator, "both packs rather weary towards the end, Bart.'s being more noticeably so."

The first half was rather scrappy. King's were very nearly over on three occasions but there was fortunately someone to stop a try each time. Bart.'s only settled down in the last twenty minutes and

then scored two quick tries following a goal scored by King's. The first, by M. Laybourne after a quick heel from a loose scrum, and the second by A. R. Corbett who had backed up a long run by A. J. H. Spafford. In the last minute of the game King's scored an unconverted try in the corner to draw.

The Bart.'s forwards were slower than their opponents whose play and backing up in the loose was ably directed by W. B. Young. In the lines out, too, the Hospital were not so sure in their catching, and occasionally allowed an opponent to break through. The three-quarters only played well during the second half, the passing and handling being rather uncertain at first. They have not yet attained the smoothness in their combination which produced so many tries last season.

The result was a fair one. The standard of Bart.'s play will have to improve if some of the harder matches later in the season are to be won. As an aid to this a few more touchline supporters would be most welcome. If we had only a quarter of the number of students and staff to cheer us that King's had for this match we should certainly play better. Meanwhile, our thanks to the faithful five.

Team: J. C. Gibson; N. A. Campbell, M. N. Laybourne; P. R. Hawkes, J. W. G. Evans, L. A. McAfee, C. S. M. Stephen; J. F. Pearce, R. J. Alcock, A. R. Corbett, R. L. Hall, A. J. H. Spafford, J. R. Moffat, J. A. T. West, J. P. Stephens.

HOCKEY

Bart.'s v. Cambridge University, at Cambridge. Draw 1—1.

This was the first fixture we had had against Cambridge, and it was obvious when we met at Liverpool Street Station that the usual pre-operative therapy would be severely frowned upon by Captain and Secretary alike. A pity, but perhaps a blessing as the trains in wartime rarely run to corridors!—and didn't.

It was a perfect day, and on a good ground before a crowd which included that keen supporter of all Bart.'s games, Professor Wormall, and a number of pre-clinicals, the game began.

The pace was very fast, and Cambridge were the first to attack. The defence remained steady, however, and gradually Bart.'s began to hit back. The first time checks and hitting of the backs and halves was a joy to watch, and it was from such a check by Hewitt that led to Bart.'s scoring, after 20 minutes' play. Hewitt put the ball down the centre to J. Fison, who made a lot of ground before passing to R. Heyland, for the latter to run in and score with a perfect cross shot.

This was a great tonic, and Bart.'s were, if possible, even quicker on the ball than before. There was a deal of midfield play, in which Currie, Marrett and Hewitt maintained a definite stranglehold on the Cambridge forwards. Half-time arrived with Bart.'s leading 1—0.

From the bully-off Cambridge attacked fiercely, and only great work by Hicks in goal kept them out. After ten minutes, however, they equalised after some clever play on the left wing. A few moments later Hicks prevented a further score by emulating the Sadler's Wells ballet in a fine "splits" save.

At the other end J. Fison put the ball in the net from a short corner, but the whistle went for "sticks," and a few moments later Heyland made a solo run and very nearly scored. So the game ended, with a draw as a very fair result, and probably the most creditable achievement in the annals of Bart.'s hockey.

In summing up, it would be difficult to single out any particular performance; but the halves, Currie, Marrett and Hewitt hardly put a stick wrong throughout the game, and the backs Brewerton and Perkins, gave Hicks in goal a confidence which was self evident in every emergency he had to cope with.

Team: G. Hicks; R. Brewerton, C. Perkins; D. Currie, R. Marrett, S. Hewitt; T. Roberts, K. Harrison, J. Fison, R. Heyland, T. Fison (Capt.).

v. Lensbury. Won 7—2.

Still smarting from our defeat at Easter we took the field thirsting for revenge. The game waxed fast and furious neither side having the advantage, until suddenly, the intrepid Roberts carving his way through a mountain of human flesh, scored as pretty a goal as man can hope to see. Inspired by this example, J. L. Fison (2) and R. Heyland added goals to bring the score to 4—0 at half-time. The second half started with a series of attacks in depth by "the enemy," which was repulsed with heavy losses, largely due to the sterling work of C. T. A. James. Three further goals were added by J. L. Fison (2) and T. N. Fison. Just before the close, Lensbury broke through to score twice. The team then started training for the next match.

Team: G. E. Hicks; R. S. E. Brewerton, N. A. Campbell; K. O. Harrison, S. R. Hewitt, C. T. A. James; T. M. C. Roberts, H. H. Bentall, J. L. Fison, R. Heyland, T. N. Fison.

v. Middlesex Hospital. Drawn 4—4.

Sorely shaken by the Conjoint results that morning, the side suffered from persistent ill-health throughout the game. In spite of this, however, we opened the scoring through Harrison. Our temerity awoke the opposition to such activity that they scored four times before half-time. This in turn stirred our forwards to prodigies of valour, and we replied through Bentall and the inevitable J. L. Fison (2), being narrowly prevented from winning when the last shot of the game, a cannon-ball shot from Fison, struck the post.

Team: G. E. Hicks; C. P. Perkins, R. S. E. Brewerton; D. Currie, S. R. Hewitt, C. T. A. James; K. O. Harrison, H. H. Bentall, J. L. Fison, R. Heyland, T. N. Fison.

v. Richmond and Kingston. Lost 1—4.

Disease and pestilence having laid waste our entire half line, the side had to be radically reorganised, at the expense of the forwards. The game which ensued was enjoyable enough, though it was conducted very much on the defensive. J. L. Fison scored for us, and had it not been for excellent anticipation and clean clearing by Danby and Brewerton the opposition might easily have scored more than four goals.

Team: G. E. Hicks; R. S. Brewerton, A. J. Danby; F. G. Morse, R. Heyland, C. P. Perkin; T. M. C. Roberts, K. O. Harrison, J. L. Fison, H. H. Bentall, T. N. Fison.

SOCIETY OF APOTHECARIES OF LONDON

Dates of the Society's Examinations for the month of January:—

Surgery	12, 14, 15.
Medicine, Pathology and Forensic Medicine	19, 21, 22.
Midwifery	20, 21, 22, 23.

IN OUR LIBRARY

IX. *Wiseman's Severall Chirurgicall Treatises,* 1676.

By JOHN L. THORNTON, LIBRARIAN.

Richard Wiseman was born in 1622, and after being apprenticed to the Barber Surgeons, entered the Dutch Naval Service. He was later a surgeon in the Royalist Army during the Civil War, and throughout the Commonwealth served as surgeon in the Spanish Navy. From these hard schools he emerged a skilful operator, achieving the title of "first of the great English surgeons," being the forerunner of Cheselden, Pott and Hunter. Incidentally he was a contemporary of Thomas Sydenham (1624-1689), but they fought on opposite sides during the Civil War, so that contact was not of a friendly character.

In 1672 Wiseman issued *A treatise of wounds,* London, 1672, a most rare volume of which copies exist in the British Museum and the Army Medical Library. This was incorporated in his later publication, of which it has erroneously been called the first edition. The title page of our copy reads, *Severall chirurgicall treatises. By Richard Wiseman, Serjeant-Chirurgeon. London, printed by E. Flesher and J. Macock, for R. Royston Bookseller to His Most Sacred Majesty, and B. Took at the Ship in St. Paul's Church-yard, Anno Dom.* 1676. It is a folio, dedicated to King Charles II, and contains the following sections; treatises of tumours, of ulcers, diseases of the anus, of the King's Evill, of wounds, of gun-shot wounds, of fractures and luxations, of lues venerea. The book contains a description of the first case of external urethrotomy for stricture, an authentic account of "King's Evil," and tuberculosis of the joints is termed "tumor albus" for the first time.

Wiseman's book went through several editions after the one of 1676, although that being the year of the author's death, he did not revise his work. It was issued in 1686, 1696, 1705, 1719 and 1734, while a spurious "second edition," consisting of copies of the 1676 and 1686 editions with a new title page, was published in London in 1692 by Samuel Clement.

Further information on Richard Wiseman is provided in Sir T. Longmore's *Richard Wiseman, surgeon and sergeant-surgeon to Charles II; a biographical study,* 1891, which is not, unfortunately, in our Library; in Sir D'Arcy Power's Epoch-making books in British Surgery, VII. Severall chirurgicall treatises, By Richard Wiseman, 1676. *Brit. J. Surg.,* 16, 1928-9, pp. 357-61; and, Richard Wiseman and his times. *St. Bart.'s Hosp. J.,* 1911-2, pp. 198-201.

BART'S MEN IN THE FORCES

PRISONER-OF-WAR.

We hear that Lieutenant-Colonel G. T. Hankey is safe and is a prisoner-of-war in Germany.

ARMY.

Thornton Palmer.

SOUTH AFRICAN MEDICAL CORPS.

L. S. Brawn, Lt.-Col. R. Mundy, Capt.
M. M. Posel, Capt. J. Gluckman, Capt.
C. Glyn-Williams, Capt. C. D. Ewan, Staff-Sergt.

BIRTHS

BICKFORD.—On October 17th, 1941, at the Grenville Nursing Home, Bideford, to Honor (née Rose) and F./Lt. B. John Bickford, F.R.C.S., R.A.F.V.R.—a daughter.

GRANT.—On October 30th, 1941, at Wrecclesham Grange Nursing Home, Farnham, to Sheila (née Kingham), wife of Captain Russell Grant, R.A.M.C.—a son.

MATHESON.—On October 20th, 1941, at Lambeth Hospital, to Helen (née Cope), wife of Iain Matheson, F.R.C.S.—a son.

THORNTON PALMER.—On April 10th, 1941, to Freda, wife of Captain Thornton Palmer, R.A.M.C.—a daughter (Robina Mary).

MARRIAGES

CLEMENTS—MORGAN.—On September 9th, at St. Nicholas' Cathedral, Newcastle-on-Tyne, by the Provost (Canon G. E. Brigstocke), Patrick Ernest George, elder son of Dr. and Mrs. Ernest Clements, Middleton-on-the-Wolds, Great Driffield, E. Yorks., to Maureen, only daughter of Mr. Thomas Morgan and the late Mrs. Morgan, of Wingrove Road, Newcastle-on-Tyne.

FLETCHER—SEELY.—On October 24th, 1941, in Winchester Cathedral, Charles Montague, only son of the late Sir Walter Morley Fletcher and Lady Fletcher, to Louisa Seely, youngest daughter of Maj.-Gen. Lord Mottistone.

McOWAN—BACKHOUSE.—On November 1st, 1941, at Longdon-on-Tern, Salop, Surgeon Lieutenant Bernard M. McOwan, R.N.V.R., to Margaret Clare Backhouse.

DEATHS

BARTON.—On November 4th, 1941, at 23, Lindisfarne Road, Wimbledon, S.W.20, James Kingston Barton, M.R.C.P. (Lond.), M.R.C.S., aged 87, dear husband of Elizabeth.

BOYLE.—On October 15th, 1941, Henry Edmund Gaskin Boyle, O.B.E., F.R.C.S., late Senior Anæsthetist, St. Bartholomew's Hospital, loved husband of Mildred Boyle, 4, Cliffe Road, Godalming, Surrey, aged 66.

COHEN.—On October 16th, 1941, at Redhill County Hospital, Edgware, Dr. George Cohen, Coroner for East Middlesex.

ROBERTS.—On April 21st, 1941, in St. Peter Port, Guernsey, after a major operation, Charles Leonard Digby Roberts, M.B., Ch.B., D.T.M. & H. (R.C.P. & S.), aged 59.

EDITOR'S NOTE

Subscription rates for the Journal are: Life, £5 5s.; 5 years, £1 11s. 6d.; annual, 7s. 6d. Readers are reminded that these rates bear no relation to the nominal charge of 4d. per copy made to students, to limit numbers in view of paper shortage; 4d. actually by no means covers the cost of producing one copy.

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